Effective Pay Period Number _____

Effective Pay Period Ending Date _____

457 Plan Enrollment Change Form

Please return completed form to Human Resources.

Employee Name	Employee ID Number
Department	Employee Phone Number

I authorize a change in my per pay period contribution, amount listed below, to be deducted from my pay (specify a percentage or dollar amount):

_____% (percent of gross pay)

or

$_____ (dollar amount per pay period)

By checking the box below, I am requesting my 457 Plan contributions stop effective with the pay period following my signature.

☐ Please stop my 457 ICMA-RC Plan contributions.

To enroll in the ICMA 457 Plan, please contact Emily Knox: 303-851-1869 or eknox@icmarc.org

Employee Signature _____ Date _____

HR _____ Date _____